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SCIENCE & MEDICINE DEPT.

ROYAL COMMISSION ON HEALTH SERVICES

a submission by

THE CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY

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900 Yonge Street,
Toronto 5, Ontario

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Introduction

1. The main body of this submission has been divided into sections which correspond with the Commission's terms of reference, as set out in P.C. 1961-883.

2. Attention is drawn to the following Appendices, containing background information necessary to a presentation of the views of The Canadian Arthritis and Rheumatism Society:

Appendix A - The nature of arthritis and the other rheumatic diseases, and the existing state of knowledge about them.

Appendix B - The incidence of arthritis and the other rheumatic diseases -- showing that these are a health problem of major significance, causing widespread disability, suffering, social and economic loss.

Appendix C - The Canadian Arthritis and Rheumatism Society, its history, organization, objectives and methods - including lists of members of its National Board of Directors and National Medical Advisory Board.

3. For more than ten years, The Canadian Arthritis and Rheumatism Society has fostered research and professional education in arthritis and the other rheumatic diseases, has assisted in the establishment of arthritis clinics at general hospitals, and has provided ancillary patient care services, such as physiotherapy, occupational therapy, and medical social work, both in the hospital and in the home. From this experience, and from careful observation of rheumatic disease control programs being carried on in the United Kingdom, other European countries and the United States, there has been gathered knowledge on a scale sufficient to suggest a plan

for the orderly diagnosis, treatment and, ultimately, prevention of these diseases capable of nation-wide application. It is held that this plan could be applied without incurring vast expense, and that its progressive introduction would result in a prompt reduction in the ravages of crippling arthritis and the other rheumatic diseases, and the social and economic losses which they now cause.

4. It is recognized that many of the recommendations contained in this submission fall within the area of provincial jurisdiction. They are advanced, however, in order to clarify the program which the Society recommends, and because its implementation can be hastened through conditional subventions by the Government of Canada.

Summary of Main Recommendations

5. The Canadian Arthritis and Rheumatism Society offers three main recommendations, the first two of which are specifically concerned with arthritis and the other rheumatic diseases. The implementation of these specific recommendations would involve annual governmental expenditures of about $2,125,000 by the year 1970:

(i) The establishment of rheumatic disease units, with an average of 30 to 40 beds each, at or in association with some 25 to 30 main regional general hospitals throughout Canada, the cost of which would reach about $1,250,000 a year by 1970 (paras. 13 to 19, and 47).

(ii) Increased support for arthritis research, to reach an annual rate of $600,000 by 1966, rising to $875,000 by 1970 (paras. 51 to 60, and 48).

(iii) Expansion of the numbers of well trained professional and technical personnel essential to the provision of health care of a high standard along lines likely to be recommended by


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appropriate professional assocations, such as the Canadian Medical Association, the Canadian Rheumatism Association, the Canadian Association of Physical Medicine and Rehabilitation, the Canadian Physiotherapy Association and the Canadian Association of Occupational Therapists.

6. The Society's other recommendations are of a subsidiary or general character, having to do with the diagnosis, treatment, rehabilitation and prevention of chronic illness generally.

(A) - THE EXISTING FACILITIES AND METHODS FOR THE PROVISION OF PERSONAL HEALTH SERVICES.

7. People suffering from the various forms of arthritis and the other rheumatic diseases receive personal health care services through the facilities which have been developed to provide for the health care of sick members of the community generally. The general practice of medicine - the application of medical science and the healing arts to the needs of patients by the family physician - is the foundation upon which all other services are erected, and without which they could not stand. These other services include those of specialists in the various branches of medicine and surgery, and the divers resources of general hospitals, convalescent hospitals, chronic disease hospitals, nursing homes, home care programs, rehabilitation agencies and centres. To all of these, members of the ancillary professions and skilled technicians make their essential contributions.

8. The basic principle inherent in this system is that the treatment of arthritis and the other rheumatic diseases is integrated with general community health services. Although it recognizes important defects

in this system (which will be described later), the Society recommends that its basic principles should not be disturbed, for the following reasons:

(i) Early diagnosis is essential to the prevention of disability due to arthritis and the other rheumatic diseases. Early diagnosis can best be achieved through the family doctor.

(ii) The most serious forms of arthritis and the other rheumatic diseases, such as rheumatoid arthritis, ankylosing spondylitis, gout, disseminated lupus erythematosus, and peri-arteritis nodosa, require long term, usually life long supervision to maintain the patient's optimum health. The effective discharge of this responsibility requires the participation of the family doctor. Indeed, family doctors should be the frontline troops in the battle against arthritis and the other rheumatic diseases, and specialists and specialized facilities should be regarded as reinforcements which should be available whenever necessary to deal with particularly difficult problems and episodes.

9. While the cause, means of prevention and specific cure for many of the common and serious forms of arthritis and the other rheumatic diseases remain unknown, it has been demonstrated that the prompt and sustained application of measures of treatment already known to medical science can prevent serious disability in a majority of patients. A high standard of care is being achieved for some Canadians suffering from arthritis and other rheumatic diseases, but it is the Society's belief that this standard of care is not available to the majority of patients, numbers of whom show the devastating but needless results of serious neglect. The reasons for this unsatisfactory state of affairs include:

(i) An uneven distribution of knowledge among physicians about the diagnosis and treatment of arthritis and the other rheumatic diseases - a situation which also obtains among the ancillary

professions, such as nursing, physiotherapy, occupational therapy, rehabilitation counselling and social work.

(ii) A shortage and maldistribution of consultants well trained in rheumatology, and insufficient means to ensure that specialist consultation is readily available.

(iii) Difficulties in securing the admission of arthritic patients to hospitals, under admission policies which, usually of necessity, give preference to emergency situations and fail to recognize the prevention of crippling deformity as an urgent matter.

(iv) Shortage and maldistribution of facilities frequently essential to the prevention or correction of disability and deformity, such as physiotherapy and occupational therapy services, and other services necessary to the satisfactory care of patients in hospitals, homes and nursing homes. In some quarters, facilities of these kinds are considered to be somewhat specialized or experimental,(1) whereas they should be considered as standard and accepted.

10. These defects are usually most apparent in the smaller and more isolated communities, but they exist in substantial measure even in larger centres.

(1) According to a survey of hospitals of more than 50 beds, conducted by the Canadian Hospital Association during 1961, 234 hospitals containing 88,373 beds had physiotherapy departments, whereas 346 hospitals, having 93,192 beds did not have physiotherapy departments.

(B) - METHODS OF IMPROVING EXISTING HEALTH SERVICES

11. If satisfactory standards are to be achieved, the Society believes that the care of the chronically ill must be an integral part of the general system of medical care, at the intellectual core of which lie the great hospitals and medical schools. Similarly, the Society believes that a satisfactory program for the care of those suffering from arthritis and the other rheumatic diseases can best be assured within the framework of a satisfactory program for the care of the chronically ill generally.(2) Accordingly, the Society divides its recommendations in this section into three parts:

(i) Recommendations relating to arthritis and the other rheumatic diseases specifically,

(ii) Recommendations relating to the care of the chronically ill generally, and

(iii) Recommendations relating to the extension of health care insurance.

12. The Society's specific recommendations concerning arthritis and the other rheumatic diseases, (paras. 13 to 19), are not dependent upon its general recommendations concerning the chronically ill (paras. 20 to 28), or the extension of health care insurance (paras. 29 to 31), although it is held that its specific recommendations would achieve their maximum effectiveness if these subsidiary recommendations were also to be implemented.

(2) Arthritis and the other rheumatic diseases are the cause of a substantial proportion of all chronic illness, as illustrated by the Canadian Sickness Survey 1951 which shows that, of 963,000 persons with permanent physical disability, arthritis and the other rheumatic diseases were reported as the primary or secondary cause in 23.4%.

Recommendations relating to arthritis and the other rheumatic diseases specifically - Establishment of Rheumatic Disease Units.

13. It is recommended that rheumatic disease units be established within the Departments of Medicine in some 25 to 30 selected and well distributed major general hospitals.(3) The design of each rheumatic disease unit will vary quite considerably according to the resources available, or which can be made available. In some cases, for example, 30 or 40 beds might be assigned to the rheumatic disease unit in a large general hospital, whereas in other cases, only 7 or 8 beds might be assigned to the unit at the general hospital, supplemented by additional designated beds, suitably staffed and equipped, at an associated chronic disease or convalescent hospital.

14. The proposed rheumatic disease units would be focal points for specialized diagnosis and treatment, research, and undergraduate, graduate and continuing medical education. The degree of emphasis upon these several activities would vary as between rheumatic disease units, and not all could carry a full program. Major research expenditure, for example, should be restricted to 4 or 5 selected units, the remainder undertaking a smaller volume of research.

15. These units would also provide for the diagnosis, treatment, and rapid and orderly disposition of unusual or difficult cases. Patients should

(3) Units of this kind have been in operation for 10 to 20 years in the United Kingdom and the Scandinavian countries. Such units were established in selected veterans' hospitals in Canada by the Department of Veterans Affairs at the close of World War II. Rheumatic disease units have recently been established within the Departments of Medicine at the University of British Columbia and the University of Toronto, through the co-operative action of the universities and hospitals concerned, and The Canadian Arthritis and Rheumatism Society.

be admitted to or retained in these units only so long as they cannot be efficiently treated in other hospitals, their own homes and other less expensive facilities.(4) Experience has shown that arthritis patients even those suffering from severe disability of long standing, make excellent progress under the intensive and segregated treatment provided in such units.(5)

16. By demonstrating the highest standards of diagnosis and treatment, by stimulating research, and through their educational activities, these rheumatic disease units would exercise a profound and beneficial influence on the care of arthritic patients, far beyond the confines of the units, and thus further contribute to a significant reduction in the incidence and severity of permanent physical disability.

17. So that the professional staff of these units can adequately discharge their responsibilities for the direction of treatment, for teaching and research, and give leadership in the development of improved standards, it will be necessary to make arrangements for their compensation in a manner which will make this possible.

18. The proposed number of 25 to 30 rheumatic disease units is recommended on two bases. First, assuming that units would have somewhere between 30 and 40 beds each, this number of units should supply about 1,000(6)

(4) Average per patient stay during 1961 in the Arthritis Unit at Sunnybrook Veterans' Hospital was 35 days; average per patient stay for last six months of 1961 at the University of Toronto Rheumatic Disease Unit (Queen Elizabeth Hospital Division) was 43.5 days.

(5) During the first year of operation of the University of Toronto Rheumatic Disease Unit (Queen Eliabeth Hospital Division), 50 rheumatoid arthritis patients were treated and discharged. On entering the unit, 21 of them were gravely incapacitated (bed or wheelchair bound); 24 were seriously limited in function; and 5 were slightly limited. At discharge from hospital, however, only 5 patients remained gravely incapacitated, 12 had serious limitations, while 33 had minor limitations, or none at all.

(6) Yielding a designated arthritis bed ratio of .055 per thousand of population in Canada. In Sweden and Norway, the ratios of designated beds per thousand of population are .087 and .133 respectively.

designated arthritis beds, as recommended by the General Council of the Canadian Medical Association following a special survey carried out under the Council's direction during 1950(7). Second, it would provide for an adequate distribution of units throughout Canada, and would be compatible with the kind of regional organization of health facilities discussed later in this section.

19. It is recommended that an early start be made on the development of rheumatic disease units, so that the required number can be achieved by 1970.

Recommendations relating to the care of the chronically ill generally.

20. The total problem of chronic disease is not a series of separate problems which can be solved one by one, but rather a complex of interrelated problems which require simultaneous consideration and co-ordinated solutions.

21. The Society believes that the development and use of health resources and facilities should be regionally planned so as to achieve a proper balance among them and promote their maximum efficiency. This planning should embrace not only hospitals(8) of all classes - general, chronic and convalescent - but also a variety of related ancillary services and facilities. These include rehabilitation centres, boarding and nursing homes, homemaker services and other organized home care programs. No matter how excellent its own situation, for example, no hospital, or other institution or agency, can itself overcome all the defects within its community, let alone within a broader region. A satisfactory rate of hospital admissions and discharges, for example, leading to the most efficient use of its beds, may depend upon a sufficient supply of convalescent, rehabilitation, or nursing home facilities. The medical condition of the chronically ill person is not static, but changes with time; so, too, his medical and social needs will change.

(7) CMAJ, Sept. 1951, Vol. 65, p. 187
(8) Including planned provision of out-patient services.

22. To achieve its fullest usefulness, the concept of regional organization involves the classification of institutions according to their resources, and the classification of patients according to their changing needs. Administrative arrangements, including transportation, must be made to facilitate the transfer of patients among the different elements comprising the regional group. Regional planning will make possible the most economical and efficient use of facilities of all kinds.(9)

23. The design of a regional grouping of health resources must vary as between different sections of the country, for a variety of geographical, political and professional reasons. A single regional organization might cover an entire province, or a province might be divided into a number of regions. In any case, one, and occasionally more than one, major general hospital - preferably a teaching hospital - should lie at the heart of each regional group. Peripheral hospitals - general, convalescent and chronic, including rehabilitation centres - should be formally associated with the major general hospital upon which the region is based, as should the other ancillary facilities and services referred to earlier. What have been described as peripheral hospitals, may lie at a very considerable distance from the base hospital, or may be close at hand within the same community. Affiliation between hospitals and institutions should be developed in a manner which will facilitate teaching and consultation visits, and the appropriate disposition of patients between all the institutions forming part of the regional group.

24. Traditionally, a sharp line has been drawn between general hospitals and chronic disease hospitals. The former have been regarded as high cost

(9) "... the hospital system should be one with at least the object of having the right type of patient in the right type of bed at the right time." J.B. Neilson, M.D., Ontario Hospital Administrative Conference, October 1961, page 14.

institutions, providing complex and expensive facilities for the diagnosis and treatment of the acutely ill. The latter have been regarded as low cost institutions for the care of the chronically ill,(10) on the assumption that few of these patients require complex and expensive diagnostic and therapeutic procedures. This assumption is no longer entirely valid, for there are many chronically ill patients whose restoration to maximum functional capacity and independence of living requires them to be treated, for longer or shorter periods of time, in institutions which can provide these complex and expensive facilities. Equally, there are some acutely ill patients who do not require complex and expensive services. The Society believes, therefore, that this traditional dividing line should become progressively less distinct. The twin objectives of improved hospital treatment for the chronically ill and the most efficient use of facilities, can be approached in several ways. One way is the establishment of units for the active treatment of selected chronic disease patients as special wings or floors at general hospitals. Another, probably less desirable, way is to provide some of the complex and expensive facilities required for the active treatment of selected chronically ill patients in certain wings or floors of chronic disease hospitals. The remaining parts of these institutions could continue to provide for those patients who do not require complex and costly facilities, be they chronically ill or acutely ill. In due course, the term chronic disease hospital should disappear along with the related traditional concept, to be replaced by terms more descriptive of their proper function, serving a variety of supplementary or special purposes within the total pattern of health services.

(10) Ontario Hospital Services Commission, Annual Report, 1960, pages 69 and 73: Net allowable costs per patient per diem: - Toronto General Hospital - $26.41; Ottawa Civic Hospital - $22.78; an average of 17 hospitals for the chronically ill - $8.84.

25. Nursing homes, relying mainly upon practical nurses and the occasional supervision of professional nurses and physicians, can meet the needs of many of the chronically ill who do not require hospital care, but who cannot be cared for in their own homes. Minimum standards for nursing homes should be established, and these should include medical examination before admission, follow-up examination at definite intervals, and regular supervisory visits by physicians. Where homes for the aged provide care for the chronically ill, the same standards should apply. Many of the ancillary home care services which should be available to patients in their own homes, should also be available to them in these substitute homes.

26. The patient's own home is frequently the best possible place for the treatment of chronic illness. The doctor's ability to continue the patient's treatment satisfactorily within the home frequently depends upon the availability of homemaker, home nursing, and other home care services, such as those of visiting physiotherapists, occupational therapists and medical social workers. The relative adequacy of these services will have a definite bearing on the number of patients being admitted to hospital, and on their length of stay in hospital.

27. Sufficient medical rehabilitation personnel should be provided in the various hospitals in the region. Physiotherapists, occupational therapists, speech therapists, limb and brace makers and fitters, etc. would, however, tend to be concentrated at the major general hospitals, and at associated medical rehabilitation centres. Nevertheless, physiotherapists should also be located at all or most of the peripheral hospitals throughout the region for the treatment of both in-patients and out-patients whose conditions do not otherwise require them to be transferred to a major general hospital or other special facility within the region. In large communities where the growth of population has placed long distances between many people and their community hospitals, some consideration should be given to the establishment of physical and occupational therapy and other medical rehabilitation facilities at convenient locations.

Medical social workers should be available in all the larger hospitals within the region to develop and maintain effective liaison with governmental and voluntary agencies which provide social welfare and vocational rehabilitation services, and to assist in the solution of social problems generally.

28. The vocational rehabilitation services about to be initiated in many provinces should be closely associated with the agencies and institutions providing health services, especially health services for the chronically ill.

Recommendations relating to the extension of health care insurance.

29. About half the population is now entitled to some form of health care insurance under a wide variety of existing programs. The remainder have not provided for themselves, either because they do not need to, do not wish to, or cannot. The Society believes that the application of governmental funds should be devoted to subsidizing health care insurance for those who fall in the latter category, i.e. those who cannot be insured under existing plans by reason of their age, state of health, the hazardous nature of their occupations, or their geographic isolation. To this list of those who cannot provide for themselves must be added the indigent and the medically indigent, for whom the equivalent of health care insurance should be provided, preferably through the establishment or appropriate modification of government financed medical welfare programs.

30. All approved health care insurance programs should provide for what are sometimes called extended health benefits. Thus, in addition to the services of general practitioners, specialists and required diagnostic procedures, approved health care insurance plans should also provide

for the out-patient services (11) of physiotherapists, occupational therapists, and other ancillary therapeutic personnel, essential drugs, orthotic and prosthetic devices wherever these are medically prescribed.

31. Loss of the bread-winner's income, and loss of the services of the mother and housewife through prolonged disability are the greatest financial burdens imposed by ill health. For those unable to insure themselves against this particular hazard, the Society does not recommend a massive program of universal and compulsory sickness cash benefits. Instead, it recommends a progressive improvement in provisions for general public assistance.

(C) - CORRELATION OF NEW OR IMPROVED PROGRAMS WITH EXISTING SERVICES WITH A VIEW TO PROVIDING IMPROVED HEALTH SERVICES

32. The correlation of all health resources and facilities, both new and existing, is essential for the improvement of health services.

33. Some degree of success may be achieved through voluntary co-ordination.(12) A voluntary association of the institutions providing health services within a given region can be successful where co-operative participation tends

(11) The services of nurses, physiotherapists, occupational therapists, medical social workers, and home makers should also be made readily available as part of home care programs, but these should be subject to financial participation by the patient or a needs test in addition to medical prescription.

(12) Albert D. Kaiser, M.D., "Improving the Quality of Medical Care", A.J.P.H., Vol. 39, March 1949

towards reduced costs, as in the case of joint purchasing arrangements; or, where it tends towards improved service at a slight increase in cost, such as through the sharing of pathologists, radiologists and therapists among small hospitals, individually unable to secure the services of such specialists.(13)

34. In the development of integrated health resources, however, needs will be recognized which could be met only by the expenditure of additional funds. The governing bodies of all the hospitals concerned might quite agree, for example, that there was a need to construct additional facilities for convalescent care, but might find it impossible to agree as to which of them should shoulder the additional financial and other obligations involved. It is held that the institutions and professions rendering services should be fully represented in the direction of the policies and in the administration of funds to be made available to promote the development of integrated health resources.

(D) - FUTURE REQUIREMENTS OF PERSONNEL TO PROVIDE HEALTH SERVICES

35. All the professional and technical personnel serving in the cause of health contribute, in varying degree, to the diagnosis and treatment of patients suffering from arthritis and the other rheumatic diseases. The Society assumes that their own associations will make submissions under this heading, but wishes to draw particular attention to four of them: rheumatologists, physiatrists, physiotherapists and occupational therapists.

(13) F. B. Roth, M.D. "The Health Officer and Hospital Regionalization", C.J.P.H., Vol. 43, November 1952

36. In the Society's view, a rheumatologist is a specialist in internal medicine who has devoted at least one year of his postgraduate training to the investigation and treatment of arthritis and the other rheumatic diseases. The number of rheumatologists, so defined, has increased from about 10 in 1950, to about 75 in 1961. This is a reflection of increasing professional interest in arthritis and the other rheumatic diseases, and of the results of The Canadian Arthritis and Rheumatism Society fellowship program.(14) The rate of production of rheumatologists is dependent upon the quantity and quality of individuals available to take postgraduate medical training. Assuming that this number will not rise rapidly during the next 10 years, and recognizing the competing demands of other specialties, it should be possible to increase the number of rheumatologists to about 150 by 1970 - a number likely to be sufficient to staff the 25 to 30 rheumatic disease units which it is hoped will be established by that time, and to provide for other needed consultation services. The Society wishes to stress that the opportunity for a professionally satisfying career is the main incentive to specialism, and that a reasonable assurance that rheumatic disease units will be established will do more than anything else to ensure a sufficient supply of rheumatologists.

37. The Society recognizes and encourages a relatively new medical specialty, that of physical medicine and rehabilitation, whose practitioners are known as physiatrists. An increased supply of physiatrists will contribute to the more effective supervision of physiotherapy, occupational therapy, and other rehabilitation procedures and personnel.

38. Physical therapy and occupational therapy are usually essential for the prevention or correction of disability and deformity due to arthritis and the other rheumatic diseases. There is a marked shortage in these

(14) During this period the Society has provided 92 years of training for 65 fellows, at a cost of $414,000.

professions today, and a danger that this shortage will become much more acute unless immediate steps are taken to expand training facilities, and the supply of qualified physical and occupational therapists.(15)

(E) - METHODS OF PROVIDING ADEQUATE PERSONNEL WITH THE BEST POSSIBLE TRAINING AND QUALIFICATIONS FOR SUCH SERVICES

39. The Society will not comment on methods of training of health personnel generally. It believes, however, that the widespread deficiency of knowledge among physicians about arthritis and the other rheumatic diseases results largely from defects in their undergraduate and graduate training. Although chronic illness is probably the most difficult problem facing the general physician, this fact seems to receive too little recognition in the curricula of medical colleges.

40. Under present conditions, many medical students have limited opportunities to observe the management of arthritis and the other rheumatic diseases. This is because arthritic and rheumatic patients are seldom retained in teaching units for sufficiently long periods, and this is further complicated by the frequent lack of continuity in the clinical responsibilities of medical students. This lack of opportunity to observe the management of arthritis and the other rheumatic diseases creates a situation in which many medical graduates fail to recognize that these diseases respond favourably to good management. It is held that the

(15) A Survey conducted by the Canadian Hospital Association during 1961 located 930 practising physiotherapists employed in Canada, and 542 vacancies, and conservatively estimated that 2,700 practising physiotherapists will be required by 1970 to meet minimum needs.

establishment of rheumatic disease units, and other facilities for the care of the chronically ill, in settings where undergraduate and graduate medical education is carried out, will have the most salutary long-term effect on this aspect of medical education.

41. It is also held that the establishment of rheumatic disease units will make a most important contribution to the continuing medical education of practising physicians.

42. The organization of hospitals, and of the teaching and practice of medicine should develop along lines which emphasize the treatment and rehabilitation of the chronically ill as being within the framework of general medical responsibility.

(F) - THE PRESENT PHYSICAL FACILITIES AND THE FUTURE REQUIREMENTS FOR THE PROVISION OF ADEQUATE HEALTH SERVICES

43. Various yardsticks are available to the Commission with respect to ratios which general hospital, chronic disease hospital, and nursing home beds should hold to the population in communities of various kinds, and the physical and other standards which should apply. The Society does not believe that its recommendations would involve any significant changes in these ratios and standards.(16) It further believes that its recommendations, particularly with respect to the establishment of rheumatic disease units, could be implemented without difficulty wherever these generally accepted ratios have been attained, and would provide for efficient and economical utilization of facilities.

(16) cf Footnote (6)

(G) - THE ESTIMATED COST OF HEALTH SERVICES NOW BEING RENDERED TO CANADIANS WITH PROJECTED COSTS OF ANY CHANGES THAT MAY BE RECOMMENDED FOR THE EXTENSION OF EXISTING PROGRAMS OR FOR ANY NEW PROGRAMS SUGGESTED

44. With one major exception, that of the establishment of rheumatic disease units, it will be seen that the Society's health care recommendations apply to the chronically ill generally. It seems improbable that health care insurance, for example, could be extended on behalf of presently uninsurable persons suffering from arthritis and the other rheumatic diseases unless the same benefits were to be extended to all uninsurable people.

45. The Society has no means of estimating the costs of health services now being provided to Canadians, nor of projecting the costs which would be involved in attaining accepted ratios of hospital and nursing home beds to population, nor of estimating the cost of extending health care insurance to those who are presently uninsurable. It assumes that the Commission itself will make estimates of these kinds, and that it will receive similar estimates from appropriate organizations, such as the Canadian Hospital Association, the Canadian Medical Association, the Trans Canada Medical Plans and the Canadian Health Insurance Association. Similarly, it is assumed that the Canadian Physiotherapy Association, the Canadian Association of Occupational Therapists and other professional associations will furnish the Commission with estimates as to the costs involved in providing a sufficient supply of trained personnel.

46. For the foregoing reasons, therefore, the Society restrict its cost estimations to the two recommendations it has made which are specifically related to arthritis and the other rheumatic diseases - the establishment of rheumatic disease units (paras. 13 to 19), and increased support for arthritis research (paras. 51 to 60).

47. Government sponsored hospital insurance programs now provide for standard ward care and diagnostic services, expressed in money terms as a certain net

allowable cost per patient per diem paid to various participating hospitals. The additional costs involved in the operation of rheumatic disease units would be those which are now excluded, by law and regulation, from the calculation of net allowable per patient per diem charges, or which exceed the budgetary yardsticks employed by the various hospital insurance authorities in calculating these charges. An example of the former would be the compensation to be paid to the professional personnel of the rheumatic disease units carrying out the inter-related responsibilities for research, teaching and supervision of diagnosis and treatment, and in undertaking consultation and teaching visits beyond the confines of the units (see para. 17). An example of the latter would be provision of salaries for sufficient numbers of physiotherapists(17), occupational therapists, social workers and clerks to make possible the intensive treatment required, and for the screening of patients prior to admission and their follow-up after discharge. Bearing in mind that there will be substantial differences between the rheumatic disease units in different regions, and having regard for the experience of the Rheumatic Disease Units at the University of British Columbia and the University of Toronto, the Society estimates that these costs for an average rheumatic disease unit would amount to about $50,000 a year, exclusive of funds received by way of grants-in-aid for the support of research projects. On the basis of 25 such units, a number which it is believed should be established by 1970, this would mean an additional annual expenditure of about $1,250,000.

48. To this recommended annual expenditure of $1,250,000 should be added about $875,000 for the rheumatic disease research recommended in Section (J), para. 59, a total annual expenditure at the rate of about $2,125,000 to be attained by 1970.

(17) A 30 bed rheumatic disease unit requires, for example, the services of 2 physiotherapists, whereas teaching general hospitals in Canada have establishments (not fully manned) averaging 1.7 physiotherapists per 100 beds. (CHA Study cf Footnote (1)

(H) - THE METHODS OF FINANCING HEALTH CARE SERVICES AS PRESENTLY SPONSORED BY MANAGEMENT, LABOUR, PROFESSIONAL ASSOCIATIONS, INSURANCE COMPANIES OR IN ANY OTHER MANNER

49. The Society has no recommendations or comments to make under this heading. It assumes that the specified groups will make their own submissions to the Commission.

(I) - THE METHODS OF FINANCING ANY NEW OR EXTENDED PROGRAMS WHICH HAVE BEEN RECOMMENDED

50. For the reasons cited in paragraphs 45 and 46, the Society has restricted its cost estimates to those of its recommendations which apply specifically to arthritis and the other rheumatic diseases. It similarly restricts its comments on financing to the same proposals. It is believed that the additional costs involved in the operations of the proposed rheumatic disease units should be financed by a slight extension of the existing government sponsored hospital insurance programs, although some of these costs might well be recovered from existing or extended health insurance programs. The funds required for arthritis research should come from the consolidated revenues of the Government of Canada.

(J) - THE RELATIONSHIP OF EXISTING AND ANY RECOMMENDED HEALTH CARE PROGRAMS WITH MEDICAL RESEARCH AND THE MEANS OF ENCOURAGING A HIGH RATE OF SCIENTIFIC DEVELOPMENT IN THE FIELD OF MEDICINE IN CANADA

51. The Society recommends that the Commission give favourable consideration to measures designed to strengthen support for medical research generally. In the following paragraphs the Society offers specific recommendations with respect to research in arthritis and the other rheumatic diseases.

52. Research in arthritis is research in a field of medicine of increasing significance. It is not research in any one discipline or medical science, nor is it research confined to the laboratory on the one hand, or the clinic or the community on the other. For the very reason that the natural history and basic cause of many of the serious forms of arthritis and the other rheumatic diseases remain unknown, the varied experience, insights and skills of those in basic science, the clinic and the community must be combined within the framework of a well articulated research program.

53. Major discovery is not the sole objective of medical research.(18) The acquisition of knowledge about arthritis and the other rheumatic diseases is progressing rapidly in many countries. It is essential that personnel trained in research be available at Canadian medical schools and their associated teaching hospitals to investigate the practical application of new knowledge and materials, so that teaching may be based on firsthand experimental and clinical experience. The establishment of rheumatic disease units, as recommended in paragraphs 13 to 19 of this submission, will contribute greatly to a balanced approach to the inter-related problems of research, education and high quality of medical care.

(18) Dean J. B. Collip, Ont. Med. Rev. 28, p. 268 - ". . . the more frequently the medical student is exposed to the philosophy and methodology of research, preferably by taking an active part in it himself, the more rational will be his approach to the multitude of problems he will encounter in the practice of his future profession."

54. Good research, education and patient care services effect a beneficial influence each on the others. Research acts as a kind of balance wheel, exercising a continuous directing and correcting effect on health service plans, programs and practice.

55. The advent of massive expenditure of public funds for the provision of health services must lead to broader concepts of the realm of public health research to embrace conscious efforts to stimulate research in those diseases which are the leading causes of morbidity and mortality. The Society recommends either:

(i) That such a concept of public health research should be specifically embodied within the Public Health Research Grants Order (P.C. 1961-17/530), or any other order-in-council or statute which may supersede it, and that the funds made available for public health research should be increased commensurately, or

(ii) That an autonomous Medical Research Council should be established by Act of Parliament, and that this same concept should be embodied in that Act.

56. The following table illustrates the growth of arthritis research in Canada from 1950 to 1961, as reflected by the arthritis research expenditures of The Canadian Arthritis and Rheumatism Society and the Department of National Health and Welfare:

	1950	1951	1952	1953	1954	1955
C.A.R.S	$4,000	68,313	93,756	95,626	38,837	55,738
D.N.H.W.	-	-	-	-	69,636	64,440
TOTAL	$4,000	68,313	93,756	95,626	108,473	120,178

	1956	1957	1958	1959	1960	1961
C.A.R.S	$81,038	99,942	88,954	115,463	167,445	198,000
D.N.H.W.	$60,620	71,995	69,270	66,599	32,709	100,000
TOTAL	$141,658	171,937	158,224	182,062	200,154	298,000

57. In any medical research program, the rate of expenditure climbs slowly in its early years, due largely to the time required to develop personnel and orient laboratories and departments. Once these have been accomplished, the rate of expenditure should climb sharply. Arthritis research in Canada has successfully reached this point. A much more rapid increase in expenditure is essential during the next few years if Canada is to derive full benefit from the effort already expended. Thereafter, when the volume of arthritis research activity has reached adequate proportions, a more gentle plane of increasing expenditure may be forecast.

58. Research workers' interest in a particular field can be retained only when they have reasonable assurance of continued support for their work. In its absence, investigators will transfer their interest to other fields, or their persons to other countries. These are imminent dangers.

59. The Society recommends that the level of governmental support for research in arthritis and the other rheumatic diseases should rise to $600,000 per annum by 1966, and thereafter continue to increase at a rate of about 10% per annum. By 1970, this would result in an annual expenditure of about $875,000. The Society's prescience does not extend beyond that date.

60. As a matter of principle, the Society holds that the fact that a voluntary agency supports research in a particular field should not be regarded by government as a reason why the support of research in the same field should be deducted from the responsibilities of tax supported research fund granting bodies. The individual and the corporation who contribute voluntarily to the support of research are seeking to provide extra research in that field, not to relieve the burden of taxes on other tax payers.

(K) - THE FEASIBILITY AND DESIRABILITY OF PRIORITIES IN THE DEVELOPMENT OF HEALTH CARE SERVICES

61. In many well informed quarters, it has been said that the chronic diseases are, in the Western World at least, the greatest challenge facing medicine in the second half of the twentieth century. The prolongation of life, which has been brought about by medical science's increasing ability to master acute and epidemic illness, is contributing to the increasing prominence of the chronic diseases in the medical spectrum. It is recommended that any system of priorities should have regard for this trend, and should not condemn the victims of lingering illness - which often rob the body of its essential vitality without taking life itself -- to a continued position of secondary concern in the planning and execution of health services. Beyond this humanitarian consideration, The Canadian Arthritis and Rheumatism Society believes that efforts to overcome the ravages of chronic disease should receive a very high priority, because of the promise this holds for alleviating the nation's burden of pain, suffering and economic loss.

(L) - SUCH OTHER MATTERS AS THE COMMISSIONERS DEEM APPROPRIATE FOR THE IMPROVEMENT OF HEALTH SERVICES TO ALL CANADIANS

62. The Society believes it should make some observations concerning the part to be played by voluntary agencies, and in particular The Canadian Arthritis and Rheumatism Society, in helping to ensure "that the best possible health care is available to all Canadians".(19)

(19) P.C. 1961-883 s.1

63. Initiative in the planning and execution of effective new projects is the golden opportunity of the voluntary agency. As a matter of principle the projects and activities of The Canadian Arthritis and Rheumatism Society are designed to stimulate or make possible effective action on the part of other agencies and groups in developing an overall program, and to provide directly only those services which it can provide more efficiently than any other agency, or which no other agency can or will provide. The Society aims to blaze a trail which other health and hospital authorities, governments and the general public can and will wish to follow.(20) This principle has been followed by the Society in promoting the development of research, professional education, public information and various aspects of patient care services, as described in Appendix C. There seems little reason to expect that the principle will be departed from in the future, regardless of the extent to which governments may assume additional responsibilities for the provision or financing of health care services.

64. Just how the principle will be applied in the future is a matter of conjecture, the most important determining factor being the extent to which governments assume added responsibilities. If, for example, all our recommendations were to be implemented, including the subsidiary recommendations regarding the provision of health care insurance and extended health benefits on behalf of those now not able to insure themselves (paras. 29 and 30), then the Society believes it would be able to withdraw progressively from, or modify its participation in, the provision of ancillary patient care services. The financial stringencies which make it difficult to extend these services more widely would be largely eliminated, and it would be possible to look forward with confidence to a steady development of adequate services of all kinds, both for in-patients, out-patients and home-patients. It also seems reasonable

(20) The Canadian Arthritis and Rheumatism Society, Director's Handbook, 1954, p. 15

to forecast a subsequent amalgamation and expansion of the agencies providing the visiting services of nurses, home makers, medical social workers and physical and occupational therapists. Such an amalgamated organization might well continue as a supplier of services under voluntary direction, much in the same way that most voluntarily directed hospitals are now suppliers of services paid for through the government sponsored hospital insurance programs.

65. If, however, only our main recommendations regarding the establishment of rheumatic disease units and the expansion of governmental support for arthritis research were to be implemented, the Society believes that the nature and extent of its own activities in research, professional education, public information and the provision of ancillary patient care services will not greatly change, although there may be changes in relative emphasis, and further opportunities opened up for experimentation in new fields of service. In either case, the Society would maintain its contributions to research and professional education in addition to those supported by government so that the Canadian people could continue to have some opportunity to work together voluntarily towards the solution of a problem which commands their attention and support.(21) Further, it is held to be desirable that such important activities as medical research and professional education should not pass entirely into the hands of the state, and that some substantial degree of voluntary effort should continue so as to ensure flexibility, and some protection against the dangers of potentially rigid public administration.

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(21) The Hon. J. W. Monteith, in his address to the 40th Annual Meeting of the Health League of Canada, May 27, 1960, said: "We in the Dominion Government appreciate the role of the voluntary agencies. Not only have they complemented the work of public authorities but more important, voluntary organizations have helped maintain the tradition of private initiative and responsibility which are the life-blood of social action in a free, democratic society".

APPENDIX "A"

ROYAL COMMISSION ON HEALTH SERVICES

a submission by

THE CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY

THE NATURE OF ARTHRITIS AND THE OTHER RHEUMATIC DISEASES AND THE EXISTING STATE OF KNOWLEDGE ABOUT THEM.

1. The words rheumatism or rheumatic disease are identical general terms which describe a wide variety of diseases having a single common feature, the disorder of connective tissues. Connective tissues are substances found in all body structures, holding them together, giving them their shape, strength and elasticity. Although they play a role in the human body similar to that of the steel framework in a building, they play a further role, as yet not fully understood, in the processes by which the body becomes subject to and protects itself from disease.

2. Although present in all the organs of the body, the connective tissues particularly pervade the organs of locomotion, bones, muscles, and joints.

3. Like so many medical terms, the word "arthritis" is derived from the Greek word "arthros", meaning joint. Those forms of rheumatic disease in which joint inflammation is a significant feature fall under this heading, whereas those forms of rheumatic disease in which joint inflammation is absent, or transitory, fall under the heading of non-articular rheumatism.

4. Like the term "stomach ache", the term arthritis describes an important component of many diseases without identifying the disease itself. To have a clear picture of the seriousness of a stomach ache, how long it will last, whether it will cause any permanent disability, and the kind of treatment which will be prescribed, it is necessary to know, for example, whether the stomach ache is caused by cancer, appendicitis, gastric ulcer, or too much Christmas dinner. In the same way there are

many different diseases which affect the joints and which differ widely in cause, symptoms, methods of treatment and the degree of disability which may result. No one can say how the patient will be affected, nor how he should be treated until the exact type of his arthritis is known. Brief or prolonged periods of hospitalization may be desirable in some cases and completely unnecessary in others. Some patients should completely abandon work at least temporarily; whereas others may stay on the job with the observance of simple precautions.

5. Most cases of arthritis belong to one of four common types -

rheumatoid arthritis, ankylosing spondylitis, osteoarthritis and gouty arthritis.

6. Rheumatoid Arthritis - Rheumatoid arthritis is a disease of the body as a whole, and not only of its joints. It usually affects young adults, particularly women. About 80% of its victims are between 20 and 50 years of age at the time of onset. Gradually increasing fatigue, pain and stiffness over a period of months or years is the common pattern of its development. It may involve any or all of the body's joints, but most commonly affects fingers, wrists, elbows, knees and feet. Sooner or later more than one joint is affected and the involvement is often symmetrical which means, for example, if one wrist joint is involved, the wrist on the opposite side eventually becomes affected. Not only do joints become swollen and painful, the patient may feel ill, may run a low fever, be excessively fatigued, and frequently loses weight and becomes anaemic. If the progress of the disease is not checked, the joints may become severely damaged and deformed and the surrounding tissues become wasted away. It must be stressed that serious crippling is not inevitable. Like other diseases, rheumatoid arthritis may be mild, moderate or severe. If neglected, however, it is capable of producing severe crippling and deformity.

7. Treatment is aimed at assisting the body's natural defences to combat the disease, and at preventing disability and deformity. This is

accomplished through a carefully balanced program of rest combined with special exercises prescribed according to the needs of each individual. This basic program of rest and special exercises is frequently supplemented by the use of various medications, plaster casts and splints.

8. Ankylosing Spondylitis - This disease is also known as Marie-Strumpell spondylitis and as rheumatoid spondylitis. Unlike rheumatoid arthritis, the joints mainly affected are those of the spine. In about 25% of cases, other joints become involved as well. This disease most often attacks men, usually young men. Intermittent or continuous pain and stiffness in the lower back is usually the first symptom. Pain on coughing or sneezing may be felt if the upper spine is involved, e.g. if the disease affects the joints between the ribs and the spine. The treatment for ankylosing spondylitis closely parallels that for rheumatoid arthritis.

9. Osteoarthritis - Osteoarthritis is essentially a wearing-out process of the weight-bearing joints, usually associated with advancing age. The wearing-out of joint structures may occur as a result of years of undue stress and strain on joints due to injury, excessive body weight or a type of occupation which subjects the joints to unusual physical strain day in and day out for much of a lifetime.

10. Osteoarthritis, therefore, most commonly affects those joints which are subjected to the greatest physical load - those carrying the body weight such as the spine, hips and knees. In addition, the small end joints of the fingers often show a knobby enlargement which is a common sign of the disease. Osteoarthritis may also occur in a single joint which has been subjected to repeated injury, or strain, or is of faulty structure.

11. The treatment of osteoarthritis is aimed at minimizing or removing the mechanical strain upon the affected joints through improvement in posture, reduction of excessive body weight, increasing the strength of the muscles supporting the affected joints, and by certain changes in the patient's routine of daily living designed to decrease subsequent wear and tear on the affected joint.

12. Gout - Gout is a strange and painful disease which is due to a chemical disorder in the body. This disorder may run in families, the first attacks usually occurring in men around forty. Recent advances in the treatment of gout now make it possible to prevent acute episodes of gout and gouty arthritis in many patients through the continuous administration of what are called uricosuric drugs. These drugs tend to compensate for the basic flaw in the patient's chemical make-up.

13. Other Types of Arthritis - There are many other and less common forms of arthritis not described in detail at this time. Among them are arthritis due to infection of the joints by various bacterial organisms, and arthritis due to repeated injury to joint structures.

14. Non-articular Rheumatism - Non-articular rheumatism is a general term used to describe rheumatic diseases which do NOT affect the joints, i.e. are not arthritic. Among these are conditions described variously as muscular rheumatism, fibrositis, myositis, lumbago, bursitis, myalgia, neuritis and neuralgia. Non-articular forms of rheumatism are more prevalent than actual arthritis. Although they may be painful, they are less serious than arthritis and do not lead to deformity. Among older people, however, the pain itself is often disabling.

Existing State of Knowledge about Arthritis and the other Rheumatic Diseases.

15. The existing state of knowledge about arthritis and the other rheumatic diseases may be summarized in two general statements:

(i) Despite a rapid increase in knowledge about arthritis and the other rheumatic diseases, the cause, means of prevention, and specific cure for most of the common and serious forms of arthritis and rheumatism remain unknown. Medical research is the prime lever by which the burden of arthritis and the other rheumatic diseases may be lifted from suffering mankind. Progress already made holds the promise of future success.

(ii) The prompt and sustained application of treatment measures already known to medical science can prevent serious disability in a high proportion of patients. To achieve such results, there must be a sufficient body of well trained personnel, supported by well organized facilities.

Recent Progress in Arthritis Research

16. In the twelve years since it happened, there has been no discovery to rival the introduction of cortisone in public acclaim and attention. In the same twelve years, the expenditure on rheumatic disease research has increased many times over. What is the explanation for this seeming paradox?

17. Part of the explanation lies in the very nature of medical research. The infrequent dramatic discoveries having immediate practical application, the ones which capture the public imagination, may be compared with fitting the critical and revealing piece into a jigsaw puzzle. The other equally important pieces have been placed in position all unnoticed amid the swirl of events.

18. The remainder of the explanation is to be found in two important facts. In the first place, there have been many recent discoveries of great importance, of which the public is all too unaware. Secondly - and to some, surprisingly - discovery is not the sole objective of a well-balanced medical research program.

19. Chemical ingenuity has produced many new steroids, cortisone-like drugs, each with its own specific advantages and disadvantages in the treatment of arthritis and the other rheumatic diseases. Clinical research has shown how and when these drugs should, or should not, be used in treatment. Clinical research involving prolonged and detailed observation of patients is of particular importance in arthritis research, because the majority of these diseases do not occur naturally in animals. This kind of investigation has produced new concepts and understanding of the nature and course of many forms of arthritis and the other rheumatic diseases.

20. For the treatment of gout, drugs have been developed which can effect nearly perfect control over acute attacks and prevent chronic joint disability.

21. Arthritis due to infections, which was once a widespread and serious problem, can now be cured, and is hardly a matter of concern today.

22. Improved drug therapy has led to a marked reduction in mortality among patients with systemic lupus erythematosus, one of the most severe and fulminating of the rheumatic diseases.

23. The effectiveness of a treatment program for the prevention of disability in rheumatoid arthritis has been demonstrated and confirmed.

24. Medical research knows no political boundaries. Information is rapidly and continuously exchanged among scientists through a highly developed network of professional and scientific journals, and the presentation of papers at national and international meetings. It is essential, therefore, to have research-trained groups at our Canadian university medical schools, so that these developments may be assessed and practising physicians informed about them, on the basis of first-hand experiment and experience. Regardless of its other contributions, our research program is essential to a steady improvement in methods and standards of patient care.

25. Steadily expanding funds have been used to develop the necessary personnel, and to make it financially possible for appropriate University departments and laboratories to engage in rheumatic disease research. Twenty-four University departments, laboratories and clinics throughout Canada are now engaged in a well-organized research program. Some are following new leads, such as the confirmed presence of a mysterious substance in the blood of rheumatoid arthritis patients, and the unexplained, but demonstrable inflammatory reactions of certain body tissues not to external agents, but to themselves. Others are painstakingly seeking to learn the fine physical and chemical structure of connective tissue, present in all joints

and organs affected by arthritis. Still others are seeking viral or bacterial causes, and some are studying the effects of new drugs and treatment measures.

26. From its first small steps, arthritis research in Canada has now reached a point from which it can, and must, take greater strides. The ultimate conquest of arthritis demands more than continuing improvement in methods of treatment. It demands measures for the prevention of the diseases themselves - PREVENTION THROUGH KNOWLEDGE.

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APPENDIX "B"

ROYAL COMMISSION ON HEALTH SERVICES

a submission by

THE CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY

THE INCIDENCE OF ARTHRITIS AND THE OTHER RHEUMATIC DISEASES IN CANADA AND THEIR SOCIAL AND ECONOMIC SIGNIFICANCE

1. Arthritis and the other rheumatic diseases constitute a health problem of national importance because of their widespread incidence, and the burdens of suffering, disability, social and economic loss which they impose. The rheumatic diseases rank second only to cardiovascular diseases among the leading causes of physical disability, as shown in the Canadian Sickness Survey, 1951. More than one million Canadians are affected by arthritis and the other rheumatic diseases.(1) Of these, 285,000 are disabled, 63,000 being totally or severely disabled.(2)

2. Each year, arthritis and the other rheumatic diseases cause Canadians to lose nine million days work, and $75,000,000 in wages alone.(3)

3. Of those disabled by arthritis and the other rheumatic diseases, 68% are of working age, 18 - 64.(2)

(1) CMAJ. 83-4-170, and Cobb, S. et al: J. Chron. Dis., 3:134, 1956
Cobb, S. et al: J. Chron. Dis., 5:636, 1957

(2) DBS, DNHW: Canadian Sickness Survey, 1951, adjusted to 1960 population estimates.

(3) DBS estimates, 1947.

APPENDIX "C"

ROYAL COMMISSION ON HEALTH SERVICES

a submission by

THE CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY

THE CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY, ITS HISTORY, ORGANIZATION, OBJECTIVES AND METHODS

History

1. In 1947, recognizing that vigorous collective action held promise of social and economic benefits of a high order, the Minister of National Health and Welfare called a conference of experts to recommend a plan to combat arthritis in Canada. The conference proposed the establishment of a national voluntary agency to stimulate, promote and co-ordinate the attack upon these diseases, resulting in the incorporation of The Canadian Arthritis and Rheumatism Society in 1948.

Objectives

2. - To foster expansion and improvement in facilities for the diagnosis and treatment, rehabilitation and welfare of sufferers from arthritis and the other rheumatic diseases.

- To provide patients and the general public with information regarding early signs of these diseases and the need for prompt treatment.

- To promote a program of research and professional education in arthritis and the other rheumatic diseases to discover their causes, develop methods of prevention and extend knowledge about their treatment.

- To raise funds for these purposes.

Organization

3. The Society is organized nationally, provincially and locally. Divisions operate in all provinces except Prince Edward Island and Newfoundland. There are more than 80 local branches, covering some 200 communities. The affairs of the Society, its provincial divisions and local branches, are governed by Boards of Directors. An integrated program is maintained by the action of the national and provincial Boards of Directors in the delegation of specific program responsibilities. The national and divisional Boards of Directors are geographically representative.

4. The Society's by-laws require medical representation on the Boards of Directors at all three levels. The National Medical Advisory Board consists of 29 representative physicians and medical scientists, and each provincial division has a medical advisory board similarly composed.

5. The Society has a professional staff of 125, most of whom are physiotherapists, but including occupational therapists and medical social workers. Most divisions have medical directors, either full or part-time.

Program

6. The widespread incidence and severity of arthritis and the other rheumatic diseases presents a problem which requires the co-operation of the medical and allied professions, hospitals and other health agencies, both governmental and private, in its solution. The program of The Canadian Arthritis and Rheumatism Society has been designed to assist other agencies, organizations and institutions to improve their own rheumatic disease programs, and all its projects are devoted to this end. The Society undertakes to provide a service directly only where other agencies and institutions are unable to do so.

7. The Society currently conducts a seven part program of attack on arthritis:

(i) Research - C.A.R.S sponsors arthritis research at university medical schools, through a program of grants and fellowships to assist

investigators to obtain the equipment, supplies, scientific and technical personnel necessary to prosecute good research.

(ii) Professional Education - C.A.R.S furnishes fellowships through which Canadian doctors may take graduate training at leading centres in the United Kingdom, United States and Canada. Fellows return to university and hospital appointments, and participate in the direction of arthritis clinics, medical teaching and research. In addition, the Society prepares teaching aids such as pathological and clinical slides, and distributes the Bulletin on Rheumatic Diseases widely among the medical profession.

(iii) Public Information - C.A.R.S provides factual information about arthritis and the other rheumatic diseases to patients and the general public through pamphlets, films, displays and other media.

(iv) Arthritis Clinics - C.A.R.S assists general hospitals to establish arthritis clinics. Such clinics become part of hospital out-patient departments and operate under their professional control. Almost every hospital in Canada with a public out-patient department now has an arthritis clinic.

(v) Physiotherapy Treatment Centres and Home Care Services - C.A.R.S provides physiotherapy in its own treatment centres or in the homes of patients unable to leave them, in communities where these facilities are not otherwise available, in order to prevent or correct disabilities due to arthritis.

(vi) Travelling Consultant Services - C.A.R.S supplies consultation services in four provinces (British Columbia, Saskatchewan, Manitoba and Nova Scotia), whereby rheumatologists see referred patients in consultation in smaller communities and rural areas.

(vii) Other Services - C.A.R.S is developing occupational therapy and medical social services in the British Columbia, Manitoba and Ontario Divisions.

Effectiveness of the Program

8. The effectiveness of the C.A.R.S program may be considered in two ways:

(i) The effectiveness of services which C.A.R.S provides directly, and

(ii) The extent to which other institutions and groups have been influenced to establish anti-arthritis programs of their own.

9. During 1960, the Society's 125 professional staff members, mostly physiotherapists, provided 144,564 treatments and consultations for 11,896 referred patients. 82% of the cases closed during the year were reported as being improved or much improved.

10. C.A.R.S patient care services have been extended to communities embracing about 50% of the nation's population.

11. Since 1949, 92 fellowships have been awarded. As a result, almost every teaching and main regional hospital in Canada now has one or more members of its staff with special training and experience in the treatment of these diseases, able to participate in teaching, the direction of arthritis clinics and clinical research.

12. Twenty-five general hospitals have received assistance in the establishment of arthritis clinics. In most cases, costs of operation have now been assumed by the hospitals concerned.

13. Arthritis research in Canada, virtually non-existent 10 years ago, now involves 24 university departments, laboratories and clinics in a well organized program.

14. Special rheumatic disease units were established recently in the Departments of Medicine at the University of British Columbia and the University of Toronto. These units resulted from the co-operative action by the Society, the Universities concerned and their associated teaching hospitals. It is expected that they will exercise a profound and beneficial effect upon standards of medical care and teaching, and contribute greatly to the

acceleration of clinical research in the rheumatic disease field. Their long term effects will be of national and international significance.

15. The increasing activity of university medical schools, in both research and professional education, is encouraging and impressive. There has been a marked increase in professional, public and governmental interest in arthritis. Most of this expanding activity has been promoted, stimulated and financed by the Society.

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As the main topic for the National Medical Advisory Board Meeting is rheumatic disease units you may wish to refresh your memory on the Society's recommendations to the Royal Commission on Health Services with respect thereto. Paragraphs particularly to be noted are: 5, 13 to 19, 47 and 48.

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Major-General Georges P. Vanier, D.S.O., M.C., C.D.
Governor-General of Canada

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THE CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY

CONDENSED STATEMENTS OF INCOME AND EXPENDITURE FOR THE YEARS 1950, 1955 AND 1960

INCOME	1950	1955	1960
Contributions	$157,862	$575,114	$ 861,537
Government grants	121,208	162,483	145,496
Other	4,968	68,802	139,176
	$284,038	$806,399	$1,146,209

EXPENDITURES			
Research grants and fellowships	$ 4,000	$ 55,738	$ 167,445
Patient care services	33,646	532,570	687,950
Professional information	2,612	17,786	27,004
Public information	735	30,255	53,396
Other	84,055	99,435	192,945
	$125,048	$735,784	$1,128,740